M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10884

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 3 mos. two weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Caroline
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hillsboro,
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Edward (Last) Armstrong
4. DATE OF DEATH: (Month) 11/9/50 (Day) (Year) 19

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: ~~not known~~ [illegible]
9. AGE last birthday: 66 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: William E. Armstrong
14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
025X Immediate cause	(a) General Paresis	known since 7/26/50
30b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE): none
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 7/26/50, 19....., to 11/9/50, 19....., that I last saw the deceased alive on 11/9/50, 19....., and that death occurred at 6:00 A. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title) ADDRESS: Crownsville, Md. DATE SIGNED: 11/9/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 11/12/50
NAME OF CEMETERY OR CREMATORY: Denton
LOCATION (City, town, or county) (State): Denton, Md.

DATE REC'D BY LOCAL REG.: Nov. 9, 1950
REGISTRAR'S SIGNATURE: R. M. Joyce
24. FUNERAL DIRECTOR: R. B. Rawlings Greensboro, Md. ADDRESS:

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NOV 21 1950
BUREAU V. R.

10885

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH — COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: EASTPORT — LENGTH OF STAY (in this place): 3 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 924 Wells Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport
STREET ADDRESS (If rural, give location): 924 Wells Ave.

3. NAME OF DECEASED (Type or Print): (First) JULIA. (Middle) BENDZUNAS (Last) BANDZUNAS

4. DATE OF DEATH: (Month) Nov (Day) 23 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb 2 1891

9. AGE last birthday: 59 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundry WORKER

10b. KIND OF BUSINESS OR INDUSTRY: USNA.

11. BIRTHPLACE (State or foreign country): Lith.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank Bendzunas

14. MOTHER'S MAIDEN NAME: Julia GAILUNAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: 216-18-9422

17. INFORMANT AND ADDRESS: Elsie SKABINSKY 924 Wells Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage with	5 days
Antecedent cause(s)	Left Hemiplegia	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Hypertension	2 years

331X
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 18, 1950, to Nov 23, 1950, that I last saw the deceased alive on Nov 23, 1950, and that death occurred at 4:50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): George C. Basil M.D. — ADDRESS: Annapolis Md — DATE SIGNED: 11-24-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 11-27-50 — NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: Nov 25, 1950 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Joseph Kasinskas — ADDRESS: 602 Washington Blvd. Baltimore, Md.

4697

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NOV 28 1950.
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10886

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Gambrills
LENGTH OF STAY (in this place): 61 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Gambrills
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Hilda (Middle) Elizabeth (Last) Beck

4. DATE OF DEATH: (Month) Nov (Day) 17 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Nov 12, 1889
9. AGE last birthday: 61 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Millersville Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John C Baldwin
14. MOTHER'S MAIDEN NAME: Annie Dunson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):
16. SOCIAL SECURITY No.: None.
17. INFORMANT AND ADDRESS: Mrs Madeline Morris

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	5 Min
260X Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arterio-Sclerosis	15 Years.
61	(c) Diabetes Mellitus	25 Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None.
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify): No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to Nov 17, 1950, that I last saw the deceased alive on Nov 12, 1950, and that death occurred at 6:55A m., from the causes and on the date stated above.

SIGNATURE: Edward G Sherritt — (Degree or title): M.D. — ADDRESS: Gambrills Md — DATE SIGNED: 11-17-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 11/20/50 — NAME OF CEMETERY OR CREMATORY: Church of the Ascenion — LOCATION (City, town, or county) (State): Bowie, P.G.Co. Md

DATE REC'D BY LOCAL REG.: Nov. 20, 1950 — REGISTRAR'S SIGNATURE: R. M. Joyce per R.F.
24. FUNERAL DIRECTOR: T.A. Hardesty & Son — ADDRESS: Galesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 29 1950
BUREAU OF S

10887

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (In this place) 75 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 612 Chester Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural give location) 612 Chester Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
EMMA	FRANCES	BREWER	NOV.	12	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	WIDOW	Apr. 5, 1874	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U.S.N.
10b. KIND OF BUSINESS OR INDUSTRY: Laundress
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Raymond Tuers
14. MOTHER'S MAIDEN NAME: Emma Richards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: —
17. INFORMANT: (Mrs) Ruth F. Wilkie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause	(a) Cerebral Vascular Accident	Sudden
83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-sclerosis (General)	Unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John A. Caffy	M.D., Deputy Medical Examiner	Annapolis, Md.	11/12/50.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-14-50	Cedar Bluff	Annapolis Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov 13, 1950	[signature]	John M. Layla Son	Annapolis Md

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BUREAU V. S

10888

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co. General Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Edgewater
STREET ADDRESS (If rural, give location) Edgewater P.O. Md.

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) R (Last) CADLE
4. DATE OF DEATH (Month) 11 (Day) 24 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify) Widower
8. DATE OF BIRTH 5/23/1874
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Carpenter
11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Cadle
14. MOTHER'S MAIDEN NAME Nora Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs. Virginia Price

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis Chr and Myocardial	Sevel
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Insufficiency	Years
93d	(c) Arteriosclerosis generalized	Sevel Years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-22, 1950, to 11-24, 1950, that I last saw the deceased alive on 11-24, 1950, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 11-26-50

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~ DATE THEREOF 11/26/1950 NAME OF CEMETERY OR CREMATORY Edwards Chapel LOCATION (City, town, or county) Parole Md. (State)

DATE REC'D BY LOCAL REG. Nov. 26, 1950 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

30849

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
NOV 28 1950
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1 mos. 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Queen Anne
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Queen's Town,
STREET ADDRESS (If rural, give location) not known

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Chance
4. DATE OF DEATH (Month) (Day) (Year) 11/21/50 19

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH 2/21/74
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Camden, New Jersey
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Chance
14. MOTHER'S MAIDEN NAME not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
442x	Immediate cause	(a) Chronic Myocarditis	known since 10/17/50
131a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-Renal Disease	" "
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile "

19a. DATE OF OPERATION nonr
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) none
TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 10/17/50 19....., to 11/21/50 19....., that I last saw the deceased alive on 11/21/50, 19....., and that death occurred at 1:00 P.m m., from the causes and on the date stated above.

SIGNATURE Jacob Hungerstein M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 11/21/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 25. 1950
NAME OF CEMETERY OR CREMATORY Union Church
LOCATION (City, town, or county) Chester (State) Md

DATE REC'D BY LOCAL REG. 11/22/50
REGISTRAR'S SIGNATURE [signature] K. M. Joyce
24. FUNERAL DIRECTOR John D. Williams
ADDRESS Easton, Md.

98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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DEC 8 1950
BUREAU V. F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10890

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport; MARYLAND; LENGTH OF STAY (in this place): 4 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 924 Jackson Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport; STREET ADDRESS (If rural, give location): 924 Jackson Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
GLADYS	VIRGINIA	CLARCK	November 29 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	May 12, 1907	43 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housewife	West Virginia	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
E. A. Hickman	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	232-05-7293	husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Generalized carcinomatosis #199	2 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of cervix uteri #171	2 years
	(c)	

1718
48a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
December 1947	Extensive carcinoma of cervix grade IV	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9/2, 1950, to 11/29, 1950, that I last saw the deceased alive on 11/27, 1950, and that death occurred at 9:05 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. H. Dudley	A. H. DUDLEY, M.D.	USNH, ANNAPOLIS, MARYLAND	11/29/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	December 2, 50	Glen Haven Cemetery	Glen Burnie, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 1, 1950	M. E. French	B. L. Lepping & Son	Annapolis, Md.

RECEIVED
DEC 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10891

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Shady Side
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: West Shady Side

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland. COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Shady Side
STREET ADDRESS (If rural, give location): West Shady Side

3. NAME OF DECEASED (Type or Print): (First) Minnie (Middle) Louisa (Last) Conner.

4. DATE OF DEATH: (Month) Nov. (Day) 19 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: June 1st '75

9. AGE last birthday: 77 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dressmaker

10b. KIND OF BUSINESS OR INDUSTRY: self-

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Wallace Owings

14. MOTHER'S MAIDEN NAME: Mary Anne Tydings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Preston Owings - Shady Side Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Metastatic Cancer. —

154X **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer of Rectum. — 3 yrs. 1 mo.

46d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None.

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9.21.50, 19....., to 11.19.50, 19....., that I last saw the deceased alive on 11.18.50, 19....., and that death occurred at 3:15 P.m., from the causes and on the date stated above.

SIGNATURE: Bowie Linn (Degree or title) ADDRESS: Grandma. Shady Side, Md. DATE SIGNED: 11.19.50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 11/22/50

NAME OF CEMETERY OR CREMATORY: Quaker

LOCATION (City, town, or county) (State): Galesville, Md

DATE REC'D BY LOCAL REG.: Nov. 20

REGISTRAR'S SIGNATURE: F. B. Dent

24. FUNERAL DIRECTOR ADDRESS: T.A. Hardesty & Son, Galesville, Md

43406

RECEIVED
NOV 29 1950

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10892

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville; LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Indian Landing Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waterbury

STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ALICE	MARIE	DIGGS	November	14	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Colored	Single	12/17/27	22 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Waterbury Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Summerfield Diggs

14. MOTHER'S MAIDEN NAME: Eleanor Simms

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Harry Butler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxia due to carbon monoxide

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

891.5

178 B

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Road

(CITY OR TOWN) (COUNTY) (STATE): Indian Landing Road, Millersville, A. A. Co.

TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 14, 1950 ? m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Inhalation of exhaust fumes

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: William V. Lovett (Degree or title)

ADDRESS: 700 Fleet St., Balto., Md.

DATE SIGNED: Nov. 15, 1950

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) | DATE THEREOF: 11-18-1950 | NAME OF CEMETERY OR CREMATORY: Waterbury | LOCATION (City, town, or county) (State): Waterbury Md.

DATE REC'D BY LOCAL REG.: Nov. 18, 1950

REGISTRAR'S SIGNATURE: M. M. Joyce per R.S.

24. FUNERAL DIRECTOR: William Reese, II-108 Washington St. Annapolis, Md.

ADDRESS:

VS. A15A

RECEIVED
NOV 29 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10893

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade; LENGTH OF STAY (in this place) 5½ months
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) BERTHA (Middle) HILDEGARDE (Last) DOCKERY

4. DATE OF DEATH: (Month) November (Day) 26 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Infant

8. DATE OF BIRTH: May 29, 1950

9. AGE last birthday: — yrs. If under 1 year: Months 5 Days 27 If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: James Dockery

14. MOTHER'S MAIDEN NAME: Anna Depon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Sgt James Dockery (Father) U.S. Army, Ft Geo G Meade, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Meningitis, suppurative.

340.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 81.0 (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that ~~I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19.....~~ and that death occurred at 1100 hrs. m., from the causes and on the date stated above.

SIGNATURE: Francis M. Fitts (Degree or title) ADDRESS: U. S. ARMY HOSPITAL Fort George G Meade, Md DATE SIGNED: 1 Dec 50

FRANCIS M. FITTS, Colonel, M.C.

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF | NAME OF CEMETERY OR CREMATORY: Post Cemetery | LOCATION (City, town, or county) (State): Ft Geo G Meade Maryland

DATE REC'D BY LOCAL REG. 27 Nov 50 | REGISTRAR'S SIGNATURE: E. K. BURNSIDE, CAPT., MSC | 24. FUNERAL DIRECTOR: Donaldson Funeral Home | ADDRESS: Laurel, Md.

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DEC 4 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10894

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D. Near Jessups
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md
COUNTY A. Ar Co
CITY (If outside corporate limits, write RURAL aod give nearest town) OR TOWN R. F. D. Jessups Md
STREET ADDRESS (If rural, give location) Near Jessups

3. NAME OF DECEASED (Type or Priot) John (First) R. (Middle) Eades (Last)

4. DATE OF DEATH Nov (Mooth) 22 (Day) 1950 (Year)

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH May 16 1890

9. AGE last birthday 60 yrs. If under 1 year Months. If under Days Hours 24 hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, eveo if retired) Janitor

10b. KIND OF BUSINESS OR INDUSTRY Elementary school

11. BIRTHPLACE (State or foreign couotry) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Eades

14. MOTHER'S MAIDEN NAME Barbara Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

(If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Alfred Long

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio Valvular with Hypertension

443 X Antecedent cause(s)

92d Diseases or conditioos, if any, giving rise to the above cause atatiog the uoderiying cause iast (b) Arterio Sclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions cootributing to the death hut oot related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While ot Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 7, 1947, to Nov 21, 1950, that I last saw the deceased alive on Nov 20, 1950, and that death occurred at 10.39 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Thos J Woolridge M.D. ADDRESS Elkridge 27 Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Nov 24 1950

NAME OF CEMETERY OR CREMATORY Family Burial Ground

LOCATION (City, town, or county) (State) Near Jessups Md

DATE REC'D BY LOCAL REG. Nov 24

REGISTRAR'S SIGNATURE Clara Hastup

24. FUNERAL DIRECTOR Ridgley

ADDRESS Selby Laurel Md

7491

VS. A15

RECEIVED
DEC 6 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10895

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH COUNTY: Anne Arundel Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md. COUNTY: Anne Arundel CO.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessups — LENGTH OF STAY (in this place): Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessups
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Camp Meade Road	STREET ADDRESS (If rural, give location): Camp Meade Road

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) Engelhaupt (Last)

4. DATE OF DEATH: (Month) Nov. (Day) 17/50 (Year) 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: April 17, 1867

9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Lohr

14. MOTHER'S MAIDEN NAME: -----Spaeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Wm. H. Engelhaupt, Jessups, A.A.Co Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Instant.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio-Vascular Hypertensive Disease — 3 yrs.

420.1 93d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1947, to Nov. 17th, 1950, that I last saw the deceased alive on 11/10/50, 19....., and that death occurred at 11.30 p.m., from the causes and on the date stated above.

SIGNATURE: Frank Shipley (Degree or title) M.D. — ADDRESS: Savage, Md. — DATE SIGNED: 11/18/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Nov. 20/50 — NAME OF CEMETERY OR CREMATORY: Loudon Park, 3801 Frederick Rd. Balto. 29, Md. — LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: 11/20/50 — REGISTRAR'S SIGNATURE: A. W. Hedrick — 24. FUNERAL DIRECTOR: Harry H. Wiltze — ADDRESS: 4101 Edmondson Ave.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10896

Evidence for addition in #21 shown on:

FILM No. G 130 JAN 18 1951

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS P.O. Bldg. Central Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena (Rural)
STREET ADDRESS (If rural, give location) NEAR RITCHIE Hghy.

3. NAME OF DECEASED (Type or Print) (First) DOUGLAS (Middle) E. (Last) EVERETT
4. DATE OF DEATH (Month) NOV. (Day) 28. (Year) 1950
5. SEX MALE
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 10/28/50
9. AGE last birthday yrs. If under 1 year Months / Days If under 24 hrs Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland - Balto. City
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Harold Everett
14. MOTHER'S MAIDEN NAME Wardel Holston
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS William Everett, Pasadena Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asperation of vomitus

922.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental suffocation

195d (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Pasadena (COUNTY) Anne Arundel (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 28-1950-8.25am
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? (1/18/51 akc)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 11/28/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 30, 1950
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) Glen Burnie (State) Md

DATE REC'D BY LOCAL REG. Nov 29, 195
REGISTRAR'S SIGNATURE L. J. DeAlba
24. FUNERAL DIRECTOR R. V. Singleton ADDRESS Glen Burnie Md

2-0-0-28-0-31-2-40-5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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RECEIVED
NOV 30 1950
PORTLAND, O.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10897

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol
LENGTH OF STAY (in this place) 60 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Franklin (Last) Faust

4. DATE OF DEATH: (Month) Nov. (Day) 19, (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: june 16, 1862

9. AGE last birthday: 88 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: farm-owner

11. BIRTHPLACE (State or foreign country): Owings, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Faust

14. MOTHER'S MAIDEN NAME: Mary Stallings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mrs. Adam Noll, Bristol, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of face

1918 Antecedent cause(s)

53 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-10, 1950, to 11/19, 1950, that I last saw the deceased alive on 11/19, 1950, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE: H Weems (Degree or title) M.D. ADDRESS: Huntingtown Md DATE SIGNED: 11/22/50

23. BURIAL, CREMATION, REMOVAL (Specify) DATE: 11/22/50 NAME OF CEMETERY OR CREMATORY: Mt. Zion LOCATION (City, town, or county) (State): Galesville, Md.

DATE REC'D BY LOCAL REG. 11/22/50 REGISTRAR'S SIGNATURE: T.M. Clayton Dep'd

24. FUNERAL DIRECTOR: T.A. Hardesty & Son ADDRESS: Galesville, MD.

VS. A15

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RECEIVED
NOV 24 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10898

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (in this place) 4 mos. 1 wk.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 824 N. Central Avenue

3. NAME OF DECEASED (Type or Print): (First) Fred (Middle) Theodore (Last) Garner
4. DATE OF DEATH: (Month) (Day) (Year) 11/10/50 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	colored	married	8/27/03	47 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Walter Garner
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: not known
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) General Paresis — known since 7/4/50

025 X 30 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) none — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) none m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 7/4/50, 19....., to 11/10/50, 19....., that I last saw the deceased alive on 11/10/50, 19....., and that death occurred at 5:40 A. m., from the causes and on the date stated above.

SIGNATURE Jacob Muncaster M.D. (Degree or title) — ADDRESS Crownsville, Md. — DATE SIGNED 11/10/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 11/14/50 — NAME OF CEMETERY OR CREMATORY Mt. Auburn — LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REG. 11/12/50 — REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR — ADDRESS: Holland Funeral Home, 1631 Druid Hill Ave.

JT

48849

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10899

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
STREET ADDRESS (If rural, give location) Gambrills, Post Office

3. NAME OF DECEASED (Type or Print) (First) EDWARD (Middle) J (Last) GERSTNER

4. DATE OF DEATH (Month) November (Day) 22, (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Feb 8, 1899

9. AGE last birthday 51 yrs. If under 1 year Months 9 Days 14 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist

10b. KIND OF BUSINESS OR INDUSTRY Auto Gov. Ret.

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John J. Gerstner

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY No. 212-10-3866

17. INFORMANT AND ADDRESS Mrs Mary LeBar Gerstner Wife Gambrills

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Accident due to Arteriosclerosis	2 Hrs
443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Hypertensive Cardio Vascular Disease	5 Years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to Nov 22, 1950 that I last saw the deceased alive on Nov 22, 1950, and that death occurred at 12:40 P m., from the causes and on the date stated above.

SIGNATURE Edward G Merritt (Degree or title) M.D. ADDRESS Gambrills Md DATE SIGNED 11-22-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 11-25-50

NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cemetery

LOCATION (City, town, or county) (State) Millersville, Md.

DATE REC'D BY LOCAL REG. Nov 24, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

32697

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NOV 27 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10900

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anna Arundel

City or town: Arundel Village
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Months

Hospital, institution, or street address where death occurred: 5328 - 4th St - 25

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A -

City or town: Arundel Village
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5328 - 4th St - 25
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jennie May Gohlinghorst

3. (b) Social Security Number

4. Sex: Female

5. Color or race: W

6.(a) Single, married, widowed, or divorced: M

6.(b) Name of husband or ~~wife~~: Frank Gohlinghorst

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): June 1st - 1887

8. AGE: Years: 63 Months: 4 Days: 29 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore - Maryland
(Town, county, and state)

10. Usual occupation: House-wife

11. Industry or business: Own - Home

FATHER
12. Name: Lew Packham
13. Birthplace: England

MOTHER
14. Maiden name: Sarah —
15. Birthplace: —

16. Informant: Frank Gohlinghorst
Address: 5328 - 4th St - 25

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 12/4/50 (month) (day) (year)

Cemetery ~~or crematory~~: Woodlawn

Location: Woodlawn, Md.

18. Funeral director: Wm. Cook, Inc.
Address: 1217 So. Paul St.

19. 12/4 1950 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1950 at 10.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 10 1950, to Nov. 29 1950 and that I last saw her alive on Nov - 26 1950

Immediate cause of death: Malnutrition — Uremia

Due to: Wasting Associated with Arthritis De Formans

Due to: 723.0

Other conditions: Arterio-sclerotic Cardio-Vascular - Renal Disease 131a
(Include pregnancy within 3 months of death)

	DURATION
Malnutrition	2 months
Uremia	2 weeks
Wasting Associated with Arthritis De Formans	2 years
Arterio-sclerotic Cardio-Vascular - Renal Disease	?

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul Lubin M.D. (M. D. or other)

Address: 320 Patapsco Ave Date signed: 11/30/50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10901

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (In this place) 20 A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural give location) Wilhelm Ave

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) M. (Last) HANDSCHUH

4. DATE OF DEATH: (Month) Nov. (Day) 16 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 6 1903

9. AGE last birthday: 47 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor Railroader

10b. KIND OF BUSINESS OR INDUSTRY: B + O. R.R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Handschuh

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 705-09-6711

17. INFORMANT: Helton Foster

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

420.1 94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffy (Degree or title) M.D. Deputy Medical Examiner — ADDRESS: Annapolis-Md — DATE SIGNED: 11/16/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Nov. 20, 1950 — NAME OF CEMETERY OR CREMATORY: Glen Haven — LOCATION (City, town, or county) (State): Glen Burnie, Md.

DATE REC'D BY LOCAL REG.: Nov. 19. 1950 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: W. Livingston — ADDRESS: Glen Burnie Md.

10247

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 21 1960

10902

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS ANNE ARUNDEL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 7 CATHEDRAL ST
STREET ADDRESS (If rural, give location) ANNAPOLIS, Md.

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) GIRL (Last) HANNON

4. DATE OF DEATH (Month) 11 (Day) 19 (Year) 50 19

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH 11-18-50
9. AGE last birthday 0 yrs. If under 1 year Months 0 Days If under 24 hrs. Hours 9 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) A.A. Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME HAROLD L. HANNON, JR.
14. MOTHER'S MAIDEN NAME IRENE J. ZBINDEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Mr. H. L. HANNON, JR #2 FATHER

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) prematurity birthwt 1-14 lbs

762.5 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) atelectasis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on 11-19, 1950, and that death occurred at 12 15 A.m., from the causes and on the date stated above.

SIGNATURE Edith Roeller, M.D. (Degree or title) ADDRESS 42 State Circle Annapolis Md DATE SIGNED 11-19-50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE 11-20-50
NAME OF CEMETERY OR CREMATORY ST. MARY'S
LOCATION (City, town, or county) (State) ANNAPOLIS, Md.

DATE REC'D BY LOCAL REG. Nov. 20, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B. L. HOPPING & SON ADDRESS ANNAPOLIS, Md.

20X180261240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

10903

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
LENGTH OF STAY (in this place) 16 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 306 W. Hawthorne Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
STREET ADDRESS (If rural, give location) 306 W. Hawthorne Road

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Eugene (Last) Haslup.
4. DATE OF DEATH (Month) Nov. (Day) 27 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Oct. 6. 1889
9. AGE last birthday 61 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coffee Processor
10b. KIND OF BUSINESS OR INDUSTRY Roasting
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Lloyd J. Haslup.
14. MOTHER'S MAIDEN NAME Florence Brohawn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 577-05-1664
17. INFORMANT Mrs. Helen M. Haslup.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Lympho Sarcoma lungs.	16 mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Cardio-Vascular Renal disease	12 mos.

200.1
47d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1949, to Nov. 27, 1950, that I last saw the deceased alive on Nov. 27, 1950, and that death occurred at 10:40 A.m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr. (Degree or title) MD ADDRESS Linthicum DATE SIGNED 11/27/50 Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 30-1950
NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
LOCATION (City, town, or county) Baltimore Md (State)

DATE REC'D BY LOCAL REG. 11/29/50
REGISTRAR'S SIGNATURE A. W. Hedrich
24. FUNERAL DIRECTOR F. B. Wippert & Son - 1300 Eutaw Rd ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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10904

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: District of Columbia — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural, give location): 513-12th St. S.E.

3. NAME OF DECEASED (Type or Print): (First) [redacted] (Middle) PAUL (Last) SANFORD HAWES
4. DATE OF DEATH (Month) Nov. (Day) 3 (Year) 1950
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: July 6, 1913
9. AGE last birthday: 37 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WELDER
10b. KIND OF BUSINESS OR INDUSTRY: BRIDGE
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard Hawes
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 228-03-1408
17. INFORMANT:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Electrocution — Sudden

914.8

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Accidental

193

(c)

11. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): New Severn River Bridge — (CITY OR TOWN) near Annapolis — (COUNTY) A.A. — (STATE) Md.
TIME OF INJURY (Month) Nov. (Day) 3 (Year) 1950 (Hour) 12 noon
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? was working on new Bridge Construction

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffey M.D., (Degree or title) Deputy Medical Examiner — ADDRESS: Annapolis Md — DATE SIGNED: 11/3/50

23. ~~BURIAL~~, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Nov 6-1950 — NAME OF CEMETERY OR CREMATORY: Nebeger — LOCATION (City, town, or county) (State): ~~Washington D.C.~~ Fredmont Va.

DATE REC'D BY LOCAL REG.: Nov. 3, 1950 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: J. William Lee Sons Co. — ADDRESS: 464V9 Washington, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 7 1950

(Type or Print) SUSANNA HIGDON — DEATH NOV 5, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland — A. A. Co. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 123 Hilltop Rd.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md — B. COUNTY A. A. Co. Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 123 Hilltop Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	MARRIED	JAN 19, 1896	54	11	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	At Home	Cedarville, N.J.	USA

13. FATHER'S NAME: Edward Lee

14. MOTHER'S MAIDEN NAME: Isabelle Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: John A. Higdon — ADDRESS: 123 Hilltop Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastases to liver — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Carcinoma of Colon
DUE TO
(C)

153x ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
462

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1948 *to* 11/21/1950, 19__, *that I last saw the deceased alive on* 11/1/50, 19__, *and that death occurred at* 5:51 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Denis J. McGrath M. D. — 23B. ADDRESS: 1E Randall St — 23C. DATE SIGNED: 11/6/50.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	11-6-50	Glen Haven	Annapolis Blvd. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
NOV 8 1950	[illegible]	John F. Denny, Inc.	715 Light St.

VS 150

C. H. Hedrick per K. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information possible. The correct age is especially important.

MARGIN RESERVED FOR BINDING

VS. A15

10906

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH· COUNTY A.X. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN
HOSPITAL OR INSTITUTION OR STREET ADDRESS 23 BALLMAN COURT	STREET ADDRESS (If rural, give location) 23 BALLMAN COURT

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) JOHN W. HIXSON	4. DATE OF DEATH (Month) (Day) (Year) II/19/50 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months. Days	If under 24 hrs. Hours Min.
M	W	M	8/27/1887	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	B.T.C.	TENN.	

13. FATHER'S NAME JOHN W. HIXSON	14. MOTHER'S MAIDEN NAME ETTA BUTLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) — 16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS FAMILY - SAME

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) CEREBRO VASCULAR Hemmorrahge	2 hours
420.0 Antecedent cause(s)	(b) ARTERIOSCLEROSES - Generalized	
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arteriosclerotic Heart DISEASE	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 19, 1950, to Nov 19, 1950, that I last saw the deceased alive on Nov 19, 1950, and that death occurred at 12 40 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Benjamin Berdiansky	MD	5004 Ritchie Hwy	11-20-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
B	II/23/50	RED HILL	WHITWELL, TENN.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/20/50	A. W. Hedrick	[signature]	- 130 E. FORT AVE.

30819

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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M

Evidence for addition in #21 shonw on:
FILM No. G 131 FEB 26 1951

10907

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place) A. O.H.; HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Wash; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown; STREET ADDRESS (If rural, give location) Longmeadow Apts. ✓

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	PAUL	MILLS	HOLMES	NOV.	23	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
Male	White	Married	May 8 1921	29 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Toolmaker	AIRCRAFT	OHIO	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HOWARD HOLMES	RUTH MILLS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
WORLD WAR II		STEPHEN FREDRIC SCHOEN HAGERSTOWN, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) CRUSHED LEFT CHEST.	
822.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) INTENAL HEMORRHAGE	
170c	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	RITCHIE Hgwy.	near ANNAPOLIS	A.A.	Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
NOV. 23 1950 6:45 P.M.		Automobile overturned on Rte #2. (2-21-51 - ams)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Gaffney M.D.	Deputy Medical Examiner	Annapolis Md	Nov. 23. 50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 26/50	Rest Haven Cemetery	Hagerstown, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 24. 1950	Wm. J. French	Andrew K. Coffman	Hagerstown, Md.

V 04 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

9/21 20 00

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10908

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — STATE: MARYLAND
CITY (If outside corporata limits, write RURAL and give nearest town) OR TOWN: MARLEY PARK
LENGTH OF STAY (in this place): 3 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4 FORREST ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MD. — COUNTY: A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MARLEY PARK
STREET ADDRESS (If rural, give location): 4 FORREST ROAD

3. NAME OF DECEASED (Type or Print): (First) ELEXINA (Middle) (MARY) (Last) HUBBARD

4. DATE OF DEATH: (Month) 11 / (Day) 20 / (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: Nov. 23, 1876

9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM HUBBARD

14. MOTHER'S MAIDEN NAME: MARY ELIZABETH WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: MRS MARY GILBERT 4 FORREST ROAD MARLEY PK.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio Vascular Disease. — Interval between onset and death: about 1 yr.

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Dementia. — 3 yrs. from History

932 (c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from Feb 15, 1950, to Nov 20, 1950, that I last saw the deceased alive on Nov 16, 1950, and that death occurred at 11:20 A.m., from the causes and on the date stated above.

SIGNATURE: Joseph Lipsky M.D. — (Degree or title) — ADDRESS: Allentown Md. — DATE SIGNED: Nov 21-1950

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 11/22/50 — NAME OF CEMETERY OR CREMATORY: MT OLIVET — LOCATION (City, town, or county) (State): FREDERICK ROAD

DATE REC'D BY LOCAL REG.: Nov 21 1950 — REGISTRAR'S SIGNATURE: L. J. DeAlba

24. FUNERAL DIRECTOR — ADDRESS: JOHN F. DENNY, INC. 715 LIGHT ST -30

Dr Joseph Lipsky

99 Glen Burnie 696

Adventure " " 4154

RECEIVED
NOV 22 1950
BUREAU V. S

FHM No. G 130 JAN 18 1951

Evidence for addition in #21 shown on:

10909

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft. George G. Meade — LENGTH OF STAY (In this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Harmans
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Army Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	HAROLD	A	JOHNSON	November	27	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Colored		Jan. 31, 1931	19 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		Harmons, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel J. Johnson	Viola M. Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	
			Samuel T. Johnson	Harmans, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
823.5 Immediate cause	(a) Fracture of skull	
MoC Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Extradural hemorrhage	
	(c) Contusion of brain	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Public	nr. Ft. Meade, A.A. Co.		Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐	Not while at work ☐	HOW DID INJURY OCCUR?
11-26-50 4.45 P.m.			Passenger in auto which failed to negotiate a curve & hit a tree & telephone post.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death, in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.* (1/18/51 - ams)

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William Howard	M.D.	700 Fleet Street	11-28-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	12-1-1950	Saints Rest Cem.	Harmons	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/30/50	A. W. Jacobs	Mrs Nettie R. Williams	322 N Schroeder St.

JT

Evidennce for addition in 18 shown on:

FILM No. G 1 29 NOV 21 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21 16910

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jones near Annapolis — LENGTH OF STAY (in this place): 10 Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jones near Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Jones near Annapolis	STREET ADDRESS (If rural give location): Jones near Annapolis

3. NAME OF DECEASED (Type or Print) (First) Lloyde (Middle) (Last) Johnson			4. DATE OF DEATH (Month) (Day) (Year) 19 11/ 10/1950		
5. SEX: Male	6. COLOR OR RACE: Colo red	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: 7/31/1890	9. AGE last birthday: 60 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labored	10b. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Lloyde Johnson			14. MOTHER'S MAIDEN NAME: Hattie Brown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----		16. SOCIAL SECURITY NO. ----------	17. INFORMANT: Charles Johnson		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pneumonia, lobar (11-21-50 akc)

490 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

108 (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-5, 1950, to 11-10, 1950, that I last saw the deceased alive on 11-9, 1950, and that death occurred at 11:00 A m., from the causes and on the date stated above.

SIGNATURE: A. T. Allen (Degree or title) MD — ADDRESS: 10 Carroll — DATE SIGNED: 11-11-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 11/12/1950	NAME OF CEMETERY OR CREMATORY: Brewer Hill Cemetery	LOCATION (City, town, or county) (State): West St. Annapolis, Md
DATE REC'D BY LOCAL REG.: Nov. 12, 1950	REGISTRAR'S SIGNATURE: [signature]	24. FUNERAL DIRECTOR: Mrs. Charles E. Hicks & Son	ADDRESS: 43 Northwest

98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
NOV 14 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1911

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park
LENGTH OF STAY (in this place): 11 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cedar Crest N.Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 4016 Duvall Ave.

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) C. (Last) Jones

4. DATE OF DEATH: (Month) Nov. (Day) 17 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 21, 1863

9. AGE last birthday: 86 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Cigar Maker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry C. Jones

14. MOTHER'S MAIDEN NAME: Elizabeth Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Cedar Crest N.Home Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): General Arteriosclerosis — Interval Between Onset and Death: ?

450.0 97

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b): Senility — ?

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December, 1949, to Nov. 17, 1950, that I last saw the deceased alive on II/15/50, 19..., and that death occurred at 8.45 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Gustave A. Gruber M.D. — ADDRESS: Glen Burnie, Md. — DATE SIGNED: II/17/50

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation — DATE THEREOF: 11/18/50 — NAME OF CEMETERY OR CREMATORY: Green Mount — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG.: Nov. 17 - 1950 — REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Wm. Cook, Inc. — ADDRESS: 1217 St. Paul Street

MS

496X6

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lambrills (Rural) LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Defense Highway.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lambrills (Rural)
STREET ADDRESS (If rural give location) Defense Highway

3. NAME OF DECEASED (Type or Print) (First) JESSE (Middle) PELL (Last) KELSEY
4. DATE OF DEATH (Month) Nov. (Day) 12 (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Sept. 20, 1878
9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect
10b. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (State or foreign country) NEW YORK
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME CHESTER KELSEY
14. MOTHER'S MAIDEN NAME MADELINE JOCELYN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES, Spanish Am.
16. SOCIAL SECURITY NO.
17. INFORMANT MRS CLED KELSEY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	B Carcinoma of Stomach	7 years ~~SUDDEN~~
151X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 46b (b)	A Hemorrhage	SUDDEN
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 11/12/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF ~~[illegible]~~ 11-17-50 NAME OF CEMETERY OR CREMATORY Galloch Cemetery LOCATION (City, town, or county) (State) Hillsville, Virginia

DATE REC'D BY LOCAL REG. Nov. 13, 1950 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B. F. Hopping & Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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BUREAU OF

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1913

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
MARYLAND
LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ANN	ELIZA	KLEMA		NOVEMBER	3	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
F	W	MAR	April 12, 1865	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Elbridge Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm T. Horsey	Harriet Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no		none	Mr Wm. E. Dowling, Linthicum Height

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) CORONARY THROMBOSIS	4 DAYS
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ANGINA PECTORIS	2 yrs.
94a	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec 10, 1949, to Nov. 3, 1950, that I last saw the deceased alive on Nov. 3, 1950, and that death occurred at 3:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Fulton	Linthicum M.D.	Linthicum Heights, Md	Nov 3, 1950.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov. 5 1950	Melville Cemetery	Elbridge.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov 4th. 1950	R.W.	Henry W. Jenkins + Sons, Co.	4905 York Road.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10914

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS -

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
STREET ADDRESS (If rural, give location) -

3. NAME OF DECEASED (Type or Print) (First) HANNAH (Middle) E (Last) KOLLER
4. DATE OF DEATH (Month) Nov (Day) 25 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH Aug. 4, 1868
9. AGE last birthday 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At. Home
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Norris McGinnis
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. James O. Onderdonk, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) CARBON MONOXIDE POISONING

890.0 Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

178A (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home
(CITY OR TOWN) (COUNTY) (STATE) Odenton, Anne Arundel County, Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 25, 1950 10A.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Asphyxiated by coal stove in the kitchen

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said ~~Autopsy,~~ Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Stanley K. Duclacher M.D. 700 Fleet St. Balt. Md Nov. 26, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE THEREOF 11/29/50
NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
LOCATION (City, town, or county) (State) Balto., Md.
DATE REC'D BY LOCAL REG. 11/28/50
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons ADDRESS Balto Md.

JT

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10915 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn Baltimore-25, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, Institution, or street address where death occurred: Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County:

City or town: Brooklyn Baltimore-25, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 Orchard Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Joseph Kucharski-----(Cook)

3.(b) Social Security Number: 218-14-8278

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 17, 1883

8. AGE: Years	Months	Days	If less than one day
67			..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Joseph Kucharski
13. Birthplace: Unknown

MOTHER
14. Maiden name: Magdalena Nowakowski
15. Birthplace: Unknown

16. Informant: Mrs. Rose Ruskey (Daughter)
Address: 211 Orchard Ave Baltimore-25, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-28-50 (month) (day) (year)

Cemetery or crematory: St. Stanislaus

Location: 1300 Dundalk Ave.

18. Funeral director: George A. Weber

Address: 705. S. Ann St.

19. 11/27 1950 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25th 1950, at 2:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1950, to November 25 1950 and that I last saw h.. alive on November 25 1950

Immediate cause of death	DURATION
METASTATIC CARCINOMA OF PROSTATE	1948
Due to 177X	
Due to 51b	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: CARCINOMA OF PROSTATE

Date of op. 1948

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph F. Drenga, M.D. M. D. or other

Address: 209 S. Chester St. Date signed: 11/26/50

340 V9

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

10916

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton P.O. — LENGTH OF STAY (In this place): 40 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Wilsontown

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A H.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton, P.O.
STREET ADDRESS (If rural, give location): Wilsontown (Rural)

3. NAME OF DECEASED (Type or Print): (First) HORACE (Middle) (Last) LARKIN

4. DATE OF DEATH: (Month) Nov. (Day) 27 (Year) 195[illegible]

5. SEX: Male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: MAR. 16. 1871

9. AGE last birthday: 79 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmowner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Geo. Washington Larkin

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Garfield Larkin, Odenton P.O., Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Vascular Accident	Sudden
331 X Antecedent cause(s) 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General arterio-sclerosis	4 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

John M. Clafly M.D., Deputy Medical Examiner — Annapolis Md — 11/27/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Dec. 1 1950 — NAME OF CEMETERY OR CREMATORY: Forks — LOCATION (City, town, or county): Odenton — (State): Md

DATE REC'D BY LOCAL REG.: Dec. 1, 1950 — REGISTRAR'S SIGNATURE: H. M. Joyce

24. FUNERAL DIRECTOR — ADDRESS: J. B. Johnson — Annapolis

VS. A15A

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10917

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) D.O.A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena. P.O.
STREET ADDRESS (If rural give location) Brookfield Road

3. NAME OF DECEASED (Type or Print) (First) ELEANOR (Middle) MAY (Last) LAWRENCE
4. DATE OF DEATH (Month) NOV (Day) 4 (Year) 1950

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH July 21, 1906
9. AGE last birthday 44 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator
10b. KIND OF BUSINESS OR INDUSTRY Clothing
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Gauss
14. MOTHER'S MAIDEN NAME Theresa Kelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY NO. 214-14-9402
17. INFORMANT Benj. H. Lawrence

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
422.1	Immediate cause	(a) Acute Dilatation of Heart	sudden
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-vascular disease	2 months or more
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, occident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 11/4/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 7, 1950
NAME OF CEMETERY OR CREMATORY Balto. National Cem
LOCATION (City, town, or county) Frederick Rd. (State) Md

DATE REC'D BY LOCAL REG 11/6/50
REGISTRAR'S SIGNATURE H.W. Hedrick
24. FUNERAL DIRECTOR Krause Funeral Home ADDRESS

Jm 49606 1216 S. Charles St - 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10918

1. PLACE OF DEATH — COUNTY: Ann Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park — LENGTH OF STAY (in this place): Since 10/19/50
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: ANn Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
STREET ADDRESS (If rural, give location): 419 Potapsco Ave

3. NAME OF DECEASED (Type or Print) (First) Emma (Middle) Wood (Last) Little

4. DATE OF DEATH (Month) Nov. (Day) 23 (Year) 1950 19

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 12/19/76
9. AGE last birthday: 73 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. Wood
14. MOTHER'S MAIDEN NAME: Emilio Schulty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Cedar Crest N. Home Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	12 hrs.
331X Antecedent cause(s)	(b) Hypertension	?
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) General Arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/19/50, 19 11/23/50, to ....., 19....., that I last saw the deceased alive on 11/20/50, 19....., and that death occurred at 2.30 A. m., from the causes and on the date stated above.

SIGNATURE: Gustave H Faubert MD — (Degree or title) — ADDRESS: Glen Burnie, Md. — DATE SIGNED: 11-23-50

23. BURIAL, CREMATION REMOVAL (Specify): B. — DATE: 11.25.50 — NAME OF CEMETERY OR CREMATORY: Baltimore — LOCATION (City, town, or county) (State): Balto, Md.

DATE REC'D BY LOCAL REG.: 11/24/50 — REGISTRAR'S SIGNATURE: A. W. Hedrick — 24. FUNERAL DIRECTOR: [illegible] — ADDRESS: 130 E. Fort Lane

MS

Evidence for change in #9 shown on:

FILM No. G 151 FEB 27 1951

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10919

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (In this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 321 First St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 321 First

3. NAME OF DECEASED (Type or Print) (First) GORDON (Middle) ELLSWORTH (Last) LOWMAN

4. DATE OF DEATH (Month) Nov. (Day) 30 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May 2, 1892
9. AGE last birthday 58 ~~57~~ yrs. If under 1 year: Months | Days | If under 24 hrs: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Barber
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Lowman
14. MOTHER'S MAIDEN NAME Anna C. Munford.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. 225-36-8000
17. INFORMANT AND ADDRESS Kenneth Lowman, Riva, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Suicide

974X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hanging by neck

164a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY at home (CITY OR TOWN) Eastport (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 30, 1950 m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Hanged by neck to bed-

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D. (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis Md DATE SIGNED 4-30-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 12-4-50 NAME OF CEMETERY OR CREMATORY Glen Haven Memorial LOCATION (City, town, or county) Glen Burnie (State) Md.

DATE REC'D BY LOCAL REG. Dec. 4, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Sr. ADDRESS Annapolis Md.

70089

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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RECEIVED
DEC 5 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1020

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Point Pleasant | LENGTH OF STAY (in this place) 27 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Belle Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Point Pleasant
STREET ADDRESS (If rural give location) Belle Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Robert	Mason, Sr.	Nov.	30	1950.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	Sept. 1, 1880	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur	Trucking	Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Mason	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	?	John R. Mason, Jr. Belle Ave Point Pleasant

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General arteriosclerosis	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility	?
	(c)	

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from July, 1950, to Nov. 30, 1950, that I last saw the deceased alive on 11/29, 1950, and that death occurred at 5:00 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Leonard A Pancher	MD	Glen Burnie, Md.	11/30/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Dec. 2 1950	Western	Baltimore	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/1/50	U. W. Hedrick	Geo. L. Schwab	Baltimore, Md.

JT

42050

10921

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 4 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 315 N. Mount Street

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Lenora McCallum

4. DATE OF DEATH (Month) (Day) (Year): 11/5/50 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 5/26/1903

9. AGE last birthday: 47 yrs. If under 1 year: Months Days — If under 24 hrs.: Hours Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none Housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Rockingham, North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Liles

14. MOTHER'S MAIDEN NAME: Lenora Worthey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: not known

17. INFORMANT AND ADDRESS: hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Septicemia	known since 3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Erysipelas of left leg	
	(c)	

052X

11

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Involutional Psychosis — known since 7/6/50

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 7/6/50, 19....., to 11/5/50, 19....., that I last saw the deceased alive on 11/5/50, 19....., and that death occurred at 5:00 P. m., from the causes and on the date stated above.

SIGNATURE: Jacob Hirschstein M.D. (Degree or title) ADDRESS: Crownsville, Md. DATE SIGNED: 11/6/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 11-9-1950 — NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem. — LOCATION (City, town, or county): Balto. (State): Md.

DATE REC'D BY LOCAL REG.: 11/8/50 — REGISTRAR'S SIGNATURE: H.W. Hedrick — 24. FUNERAL DIRECTOR: Mrs. Katie R. Williams — ADDRESS: 322 N Schroeder St.

DM

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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10922

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lipins Corner.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Lipins Corner.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Old Annapolis Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Belle C. Melvin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow.

6.(b) Name of husband or wife: Wm. H. Melvin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1887

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Charles E. Cuddy.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown.

16. Informant: Mrs. Joseph Cascio
Address: Old Annapolis Blvd.

17. (Burial, cremation, or removal. Which?) Date thereof: 11/19/50 (month) (day) (year)
Cemetery or crematory: Wesley Chapel
Location: Balto. Co. Md.

18. Funeral director: Austin E. Donovan
Address: 3818 Roland Ave, Balto Md.

19. 11-17-50 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16, 1950 at 2 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946, to Nov. 16 1950
and that I last saw h[illegible] alive on Nov. 14 1950

Immediate cause of death	DURATION
Mitral Insufficiency	4 yrs.
Interstitial	
Due to: Chronic Interstitial Nephritis	4 yrs.
Due to: Edema (Uremia)	5 yrs.
Other conditions: Hypertension	4 yrs.

214X
13a
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Barbe M.D.
M. D. or other
Address: Glen Burnie, Md. Date signed: 11/16/50

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10923

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: P.O. Glen Burnie
LENGTH OF STAY (In this place): II years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Point Pleasant

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Same — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural, give location): Same

3. NAME OF DECEASED (Type or Print): (First) James (Middle) F. (Last) Morsell, Sr.

4. DATE OF DEATH: (Month) Nov. (Day) 24 (Year) 1950

5. SEX: White Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married — 8. DATE OF BIRTH: 5/5/86 — 9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Attendant — 10b. KIND OF BUSINESS OR INDUSTRY: Tavern — 11. BIRTHPLACE (State or foreign country): Baltimore, Md. — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Henry Morsell — 14. MOTHER'S MAIDEN NAME: Mary F. Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: 212-09-5293 — 17. INFORMANT AND ADDRESS: Mrs. J.F. Morsell, Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0

Immediate cause (a) Cirrhosis of the Liver — Interval Between Onset and Death: 2 years

124.6

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) General Anorexia — 2 y.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1949 to Nov. 24 50, that I last saw the deceased alive on II/23/50, and that death occurred at 12.30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Clarence N. Faubert M.D. — ADDRESS: Glen Burnie, Md. — DATE SIGNED: II/24/50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 11/27/50 — NAME OF CEMETERY OR CREMATORY: GLEN HAVEN MEM. PARK — LOCATION (City, town, or county) (State): ANNE ARUNDEL CO. MD.

DATE REC'D BY LOCAL REG.: 11-27-50 — REGISTRAR'S SIGNATURE: L — 24. FUNERAL DIRECTOR: JOHN F. DENNY, INC. — ADDRESS: 715 LIGHT ST. (30)

71071

Dr. Sherritt

10924

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrill
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) A. (Last) Moulden

4. DATE OF DEATH (Month) Nov (Day) 14 (Year) 1950

5. SEX F
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Feb 14, 1898
9. AGE last birthday 52 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, City
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Peters
14. MOTHER'S MAIDEN NAME Peterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Thomas Moulden

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage due to Arteriosclerosis — 6 Hours

443X Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular Disease — 5 Years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to Nov 14, 1950, that I last saw the deceased alive on Nov 14, 1950, and that death occurred at 9:15P m., from the causes and on the date stated above.

SIGNATURE Edward G. Sherritt (Degree or title) M.D. ADDRESS Gambrills Md DATE SIGNED 11-15-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov 17 1950
NAME OF CEMETERY OR CREMATORY Davidsonville
LOCATION (City, town, or county) Davidsonville Md (State)

DATE REC'D BY LOCAL REG. Nov. 16, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR T.A. Hardisty & Son ADDRESS Galesville Md

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
NOV 17 1950
BUREAU OF S

10925

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY P.G.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WEST HYATTSVILLE
STREET ADDRESS (If rural give location) 5624-31 AVE

3. NAME OF DECEASED (Type or Print) (First) JAMES (Middle) DAVID (Last) O'CONNOR
4. DATE OF DEATH (Month) Nov. (Day) 7 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Apr. 17, 1907
9. AGE last birthday 43 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) TIME DRIVER
10b. KIND OF BUSINESS OR INDUSTRY Bridge Bldg.
11. BIRTHPLACE (State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME John Henry O'Connor
14. MOTHER'S MAIDEN NAME — Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 253-20-4669
17. INFORMANT Merritt Chapman, + Scott, Corp.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

912.3 Immediate cause (a) Crushed Skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden

176 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) Bridge Construction
CITY (OR TOWN) Sandy Point near Annapolis (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) Nov. (Day) 7, (Year) 1950 (Hour) 7:00 p.m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? Cable on steam hammer broke and exhaust hose hit him and threw him into hammer gate.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D., (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis Md DATE SIGNED 11/7/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 11-10-50 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG. Nov. 8, 1950 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR W.W. Taltovull ADDRESS 3619-14th St N.W. Wash. D.C.

988V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 10 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

10926

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md. — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 25 Madison St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural, give location) 25 Madison St.

3. NAME OF DECEASED (Type or Print): (First) Clara (Middle) Jane (Last) Owens

4. DATE OF DEATH: (Month) 11 (Day) 3 (Year) 1950

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 7-26-1864

9. AGE last birthday: 86 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William Basil

14. MOTHER'S MAIDEN NAME: Alethia Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: William Owens Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis + Myocardial Insufficiency — Several years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — Several years

4/22.1 93d

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to Nov 3, 1950, that I last saw the deceased alive on Nov 5, 1950, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

George J. Basil M.D Annapolis Md 11-4-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) — DATE THEREOF 11-6-50 — NAME OF CEMETERY OR CREMATORY St Annes — LOCATION (City, town, or county) (State) Annapolis Md

DATE REC'D BY LOCAL REG. Nov. 6, 1950 — REGISTRAR'S SIGNATURE J. French

24. FUNERAL DIRECTOR — ADDRESS John M. Taylor Son Annapolis Md.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10927

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian; MARYLAND; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS LOTHIAN, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ANNE ARUNDEL; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LOTHIAN POST OFFICE; STREET ADDRESS (If rural, give location) LOTHIAN, Md.

3. NAME OF DECEASED (Type or Print): (First) Nelson (Middle) S (Last) OWENS

4. DATE OF DEATH: (Month) Nov. (Day) 14 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 4 Feb 1876

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWNED HIS OWN FARM TOBACCO FARM

11. BIRTHPLACE (State or foreign country): ANNE ARUNDEL Co., Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE OWENS

14. MOTHER'S MAIDEN NAME: [illegible] ELLEN ATWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: NONE

17. INFORMANT: MRS. DOROTHY E. OWENS, LOTHIAN, MARYLAND.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cachexia	4 mos
002X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131	(b) Bilat Pulm Tuberculosis	Unk
	(c) Generalized Arteriosclerosis, severe	Unk

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ■

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Nov, 1950, that I last saw the deceased alive on Sept, 1950, and that death occurred at 9:10 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Robert B Dasher MD Upper Marlboro Md 14 Nov 50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE THEREOF: 11-17-50

NAME OF CEMETERY OR CREMATORY: MT ZION METHODIST

LOCATION (City, town, or county) (State): MT ZION, AA Co Md.

DATE REC'D BY LOCAL REG.: Nov. 16, 1950

REGISTRAR'S SIGNATURE: W.R. Clayton Dep Reg

24. FUNERAL DIRECTOR ADDRESS: BEN L. HOPPING & SON ANNAPOLIS, Md.

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10928

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills Rural | LENGTH OF STAY (in this place) birth
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills Rural
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) (Last) Ridgley

4. DATE OF DEATH (Month) Nov (Day) 29 (Year) 1950

5. SEX Male | 6. COLOR OR RACE Colored | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify) M | 8. DATE OF BIRTH 6-17-1890 | 9. AGE last birthday 59 60 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | 10b. KIND OF BUSINESS OR INDUSTRY Plastic Factory | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Ridgley | 14. MOTHER'S MAIDEN NAME Mary Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Francis Ridgley Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Occlusion — 4 hours

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. No

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-29, 1950, to 11-29, 1950, that I last saw the deceased alive on 11-29, 1950, and that death occurred at 8 am from the causes and on the date stated above.

SIGNATURE (Degree or title) O S Max Neman MD | ADDRESS | DATE SIGNED 12-1-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ | DATE THEREOF 12-2-50 | NAME OF CEMETERY OR CREMATORY Lady of the Field | LOCATION (City, town, or county) Millersville (State) Md.

DATE REC'D BY LOCAL REG. Dec. 2, 1950 | REGISTRAR'S SIGNATURE R. M. Joyce | 24. FUNERAL DIRECTOR William Reese | ADDRESS 108 Wash. St. Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10929

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
STREET ADDRESS (If rural, give location) Arnold Post Office

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	DOROTHY	V	SASADA		Nov.	9,	1950 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	Dec 23 1901	49 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	own home	Baltimore, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Borkowski	Rose Przybyszewski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	no	none	Mrs Dorothy Majerowicz Arnodd, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Myocarditis chr and Myocardial Insufficiency	Several years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	years
(c) Arteriosclerosis mild	Several yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cholecystitis	4 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 19 46, to Nov 9, 19 50, that I last saw the deceased alive on Nov 9, 19 50, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George C Bond	M.D.	Annapolis Md	11-10-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-13-50	St. Mary's Cemetery	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 13, 1950	W. T. Grunch	B.L. Hopping and Son	Annapolis, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10930

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 195 Main St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 195 Main St.

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) (Last) Schmitz

4. DATE OF DEATH: (Month) Nov. (Day) 1, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept 14, 1899

9. AGE last birthday: 51 yrs. If under 1 year: Months 1, Days 16; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: A.A.Co. Election Office

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bernard Schmitz

14. MOTHER'S MAIDEN NAME: Ann Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: ?

17. INFORMANT AND ADDRESS: Mrs George Abram Moss Annapolis, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Sudden

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) F

117a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or coudition causing death. Gastric ulcer — Several Years.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1945, to Nov 1, 1950, that I last saw the deceased alive on Oct 31, 1950, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

George C. Basil M.D. Annapolis Md — 11-1-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Nov. 4, 1950 — NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — LOCATION (City, town, or county) (State): Annapolis, Md

DATE REC'D BY LOCAL REG.: Nov 2, 1950 — REGISTRAR'S SIGNATURE: W. D. Crouch — 24. FUNERAL DIRECTOR — ADDRESS: B.L. Hopping and Son Annapolis, Md.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY: A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hanover, R.F.D.
LENGTH OF STAY (in this place): 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: near Dorsey

2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hanover, R.F.D.
STREET ADDRESS (If rural, give location): near Dorsey

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Mamie E. Simms

4. DATE OF DEATH (Month) (Day) (Year): Nov. 19th 1950

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Oct. 1st 1870
9. AGE last birthday: 80 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dup.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): P. G. Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oscar Dublin
14. MOTHER'S MAIDEN NAME: Frances Adams.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Frances Matthews, Hanover, R.F.D.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Haemorrhage	2 days
331X Antecedent cause(s)	(b) Arterio-sclerosis	2 yrs.
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ✓
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): ✓
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ✓
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1st, 1949, to Nov. 19, 1950, that I last saw the deceased alive on Nov. 19, 1950, and that death occurred at 9:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank Shipley, M.D., Savage, Md. 11/20/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Nov. 24-50
NAME OF CEMETERY OR CREMATORY: St. Rest Cem.
LOCATION (City, town, or county) (State): Hanover, R.F.D.

DATE REC'D BY LOCAL REG.: 11/24/50
REGISTRAR'S SIGNATURE: A. W. Hedrick
24. FUNERAL DIRECTOR ADDRESS: Mrs George H. Holland
1631 Third Hill Ave

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10932

Reg. Dist. No. 53

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LINTHICOMB HEIGTS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS WINTERSON ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE
STREET ADDRESS (If rural give location) 14 BOND

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) (Last) SMALL
4. DATE OF DEATH (Month) NOV (Day) 7 (Year) 1950
5. SEX MALE
6. COLOR OR RACE NEGRO
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH
9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CEMENT LABORER
10b. KIND OF BUSINESS OR INDUSTRY ROADS
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

830.5 Immediate cause (a) CRUSHING INJURIES TO ABDOMEN — SUDDEN

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

170c (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) WINTERSON RD
(CITY OR TOWN) near Linthicomb Heights (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) Nov. (Day) 7 (Year) 1950 (Hour) 3.45 p.m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? Crushed between Truck & Paving Truck backing up.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 11/7/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 11-11-50
NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.
LOCATION (City, town, or county) Brooklyn Md (State)
DATE REC'D BY LOCAL REG. 11/10/50
REGISTRAR'S SIGNATURE A.W. Hedrick
24. FUNERAL DIRECTOR Choy O. Wilson ADDRESS 1000 Brantly Ave

988 V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10933

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LINTHICUM HEIGHTS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 107 TWIN OAKS RD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 107 TWIN OAKS. Rd.

3. NAME OF DECEASED (Type or Print): (First) HENRY (Middle) (Last) SONDERGELD

4. DATE OF DEATH: (Month) Nov. (Day) 23 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Mar.

8. DATE OF BIRTH: Dec. 18- 1862

9. AGE last birthday: 87 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Florist -

10b. KIND OF BUSINESS OR INDUSTRY: later Butcher emp.

11. BIRTHPLACE (State or foreign country): Balto Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Theodore Sondergeld

14. MOTHER'S MAIDEN NAME: Romula Coleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Annie C. Sondergeld - 107 Twin Oak Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Gastric Hemorrhage	24 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of the stomach	6 mo.
	(c)	

151X
462-

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 23, 1950, to Nov 23, 1950, that I last saw the deceased alive on Nov. 23, 1950, and that death occurred at 1:45 P m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
C. Milton Linthicum, M.D. Linthicum Heights, Md Nov 23, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 11/27/50 | NAME OF CEMETERY OR CREMATORY: Holy Redeemer | LOCATION (City, town, or county) (State): Balto Md

DATE REC'D BY LOCAL REG. 11/24/50 | REGISTRAR'S SIGNATURE: a-W. Hedrick | 24. FUNERAL DIRECTOR: H.J. Ruck | ADDRESS: 5305 Harford Rd

MSV

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10934

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) D.C.A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 1630-25th St. S.E

3. NAME OF DECEASED (Type or Print) (First) Ducilmer (Middle) A. (Last) STANSBURY
4. DATE OF DEATH (Month) Nov. (Day) 5 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH 12/28/1879
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Plumber
10b. KIND OF BUSINESS OR INDUSTRY Plumbing.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William W. Stansbury
14. MOTHER'S MAIDEN NAME Mary S. Thorne
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Jack Stansbury

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Coronary sclerosis	unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D., (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 11/5/50.

23. BURIAL, CREMATION REMOVAL (Specify) burial
DATE THEREOF Nov 7-50
NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
LOCATION (City, town, or county) Suitland (State) Maryland

DATE REC'D BY LOCAL REG. Nov. 5, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Simmons Bros 2007 Nichols ave SE, ADDRESS Wash DC

348V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 7 1950
BUREAU V. S.

CERTIFICATE OF DEATH

Registered No. 21 10935

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA STEWART

2. DATE OF DEATH: 11/12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland A.A. Co.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Earlieheights

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Earlieheight
B. COUNTY: A. A. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): A. A. Co Md.
D. STREET ADDRESS (If rural, give location): Earlieheight A. A. Co. Md.

5. SEX: Female
6. COLOR OR RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Charles Stewart
8. DATE OF BIRTH: About 1891
9. AGE (In years last birthday): 58
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Housework.
11. BIRTHPLACE (State or foreign country): A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Johnson.
14. MOTHER'S MAIDEN NAME: Henrietta Jones.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Charles Stewart
ADDRESS: Earlieheight Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arthro Sclerosis Apoplexy
DUE TO
(B) Arthro Sclerosis
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: Nov 9-12

334 X ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

830

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 9, 1950, *to* Nov 12, 1950, *that I last saw the deceased alive on* Nov 12, 1950, *and that death occurred at* 830 *m., from the causes and on the date stated above.*

23A. SIGNATURE: M K Willoughby M. D.
23B. ADDRESS: Severna Park Md
23C. DATE SIGNED: Nov 13 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-17-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemtry
24D. LOCATION (City, town, or county) (State): Balto. 520 86

DATE RECEIVED BY LOCAL REGISTRAR: 11/16/50
REGISTRAR'S SIGNATURE: A. W. Hedrick
25. FUNERAL DIRECTOR: W. Br. Griggs
ADDRESS: 139 W. Hamilton St.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10936

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS COLLAGE CREEK

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
STREET ADDRESS (If rural, give location) 96 EAST

3. NAME OF DECEASED (Type or Print) (First) DANIEL (Middle) CAULK (Last) TAYLOR
4. DATE OF DEATH (Month) NOV. (Day) 20. (Year) 1950

5. SEX M.
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 5-14-1887
9. AGE last birthday 63 yrs. If under 1 year Months Days If under 24 hrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATE of MARYLAND
10b. KIND OF BUSINESS OR INDUSTRY WATCHMAN
11. BIRTHPLACE (State or foreign country) ANNAPOLIS MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES S. TAYLOR
14. MOTHER'S MAIDEN NAME ANNA V. SHERBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS JOHN M. TAYLOR ANNAPOLIS MD

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) DROWNING

929.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ACCIDENT

183 (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY College Creek (CITY OR TOWN) ANNAPOLIS. (COUNTY) A.A. (STATE) MD.
TIME OF INJURY (Month) (Day) (Year) (Hour) about Nov. 19. 1950 10 P. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Fell off wharf into Creek darkness

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 11/21/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 11-23-1950 NAME OF CEMETERY OR CREMATORY St Annes LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Nov. 22, 1950 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

60298

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

SCIENCE
NOV 27 1950
BUREAU OF S

M

10937

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6 N. Cherry Grove Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis,
STREET ADDRESS (If rural, give location) 6 N. Cherry Grove Ave

3. NAME OF DECEASED (Type or Print) (First) RICHARD (Middle) BUTT (Last) TOWNSHEND

4. DATE OF DEATH (Month) Nov. (Day) 4, (Year) 1950

5. SEX Male

6. COLOR OR RACE Whtie

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Feb. 7, 1884

9. AGE last birthday 66 yrs. If under 1 year Months 8 Days 27 If under 24 hrs. Hours Mfn.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10b. KIND OF BUSINESS OR INDUSTRY Ret. USNaval Acad.

11. BIRTHPLACE (State or foreign country) Davidsonville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Daniel Townshend

14. MOTHER'S MAIDEN NAME Manche(Townshend) Bealle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Mrs Maud Arvine Townshend Wife : Annapolis, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis	6 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Prostate gland	1½ yrs.
	(c)	

177x
51b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 1949, to 11-4-, 1950, that I last saw the deceased alive on 11-4-, 1950, and that death occurred at 6 30 p m., from the causes and on the date stated above.

SIGNATURE James R. Martin (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 11-6-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 11-7-50

NAME OF CEMETERY OR CREMATORY All Hallows Cemetery

LOCATION (City, town, or county) (State) Davidsonville, Maryland

DATE REC'D BY LOCAL REG. Nov. 6, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR ADDRESS B.L. Hopping and Son Annapolis, Maryland

30898

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
NOV 7 1950
BUREAU V. S.

10938

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) DOA
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Route #2
STREET ADDRESS (If rural give location) Bay Head

3. NAME OF DECEASED (Type or Print) (First) ELEANOR (Middle) ANDREA (Last) WAGNER

4. DATE OF DEATH (Month) Nov. (Day) 1 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH
9. AGE last birthday 44 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Albert Andrea
14. MOTHER'S MAIDEN NAME Florence Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Albert Wagner, Bay Head, R.F.D. #2, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) BULLET WOUND IN CHEST THRU HEART — INTERVAL BETWEEN ONSET AND DEATH: Sudden

976x

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

164C

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home
(CITY OR TOWN) Bay Head, Annapolis, R.F.D., (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) Nov. (Day) 1 (Year) 1950 (Hour) 6:30 A.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Self inflicted .22 cal bullet wound { Colt Revolver

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE John M. Claffey M.D., (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis Md. DATE SIGNED 11/1/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 11/4/50
NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK
LOCATION (City, town, or county) BALTIMORE Co. (State) MD

DATE REC'D BY LOCAL REG. November 4th 1950
REGISTRAR'S SIGNATURE R.W.
24. FUNERAL DIRECTOR Charles F. Evans & Son Inc. ADDRESS 118 W. Mt. Royal Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

#9

10939

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 129 DEC 8 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessups — LENGTH OF STAY (in this place): 1 Year
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MHC Jessups, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 916 Caroline Street

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Edward (Last) Walker
4. DATE OF DEATH: (Month) Nov. (Day) 24 (Year) 1950
5. SEX: Male
6. COLOR OR RACE: Negro
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH: 12-25-1894
9. AGE last birthday: 55 ~~56~~ yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Norfolk, Virginia
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Daughter-916 Caroline St, Balto.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Exhaustion — 14 Months

151 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Metastatic Carcinomatosis

46 (c) Carcinoma, gastric

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Aug. 16, 1949
19b. MAJOR FINDINGS OF OPERATION: Adenocarcinoma of Stomach (Johns Hopkins Hospital)
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1949, to Nov. 24, 1950, that I last saw the deceased alive on Nov. 24, 1950, and that death occurred at 10:30P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John A Clark MD — ADDRESS: JOHN A. CLARK, M. D., Physician in Charge, MHC Jessups Md. — DATE SIGNED: 11/25/50

23. BURIAL, CREMATION REMOVAL (Specify): Nov. 28-1950 — DATE THEREOF: Dec 2-50 — NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery — LOCATION (City, town, or county) (State): A A Co Md

DATE REC'D BY LOCAL REG.: Nov 28 — REGISTRAR'S SIGNATURE: Clara Hasleep — 24. FUNERAL DIRECTOR: Robert E Williams — ADDRESS: 1515 McElderry St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 6 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10940

33

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock View Beach
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rock View Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY -
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2309 Arlington Ave

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Marvin (Last) Wharton

4. DATE OF DEATH: (Month) Nov (Day) 13 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: March 8 1910

9. AGE last birthday: 40 yrs.

If under 1 year: Months; Days

If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Engr

10b. KIND OF BUSINESS OR INDUSTRY: Pole line equipmt

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm Henry Wharton

14. MOTHER'S MAIDEN NAME: Janie A Schnaitman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-03-1355

17. INFORMANT AND ADDRESS: Mrs Henry Wharton 2309 Arlington Ave Balto Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Metastatic Malignant melanoma	4 months.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Malignant melanoma, right thigh	1½ years.
	(c)	

190X
53

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 31, 1950, to Nov. 13, 1950, that I last saw the deceased alive on Nov. 12, 1950, and that death occurred at 7:45 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Randall M. McLaughlin	M.D.	Pasadena P.O. Md.	Nov. 13. 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 16 1950	Deer Park Cemetery	Reisterstown Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/20/50	Mary B Elsie MR	Wm Berryman & Sons	Reisterstown Md

35699

RECEIVED
NOV 20 1950
BUREAU V. S

10941

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland Park
LENGTH OF STAY (in this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 209 Poplar Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland Park
STREET ADDRESS (If rural give location) 702 Broadview Blvd.

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) TUERKE (Last) WHEAT
4. DATE OF DEATH (Month) NOV. (Day) 17 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH NOV. 20 1935
9. AGE last birthday 14 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM N. WHEAT
14. MOTHER'S MAIDEN NAME VIRGINIA TUERKE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT MARY M. JEFFRIES

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Top of HEAD Blown off with shot-gun	SUDDEN
919.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 184	(b) Accidental discharge of gun	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 209 Poplar Ave (CITY OR TOWN) Garland Park (COUNTY) A. A (STATE) Md.
TIME OF INJURY (Month) Nov. (Day) 17 (Year) 1950 (Hour) 5:30 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Accidental discharge of shot-gun by Christopher Crouse

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

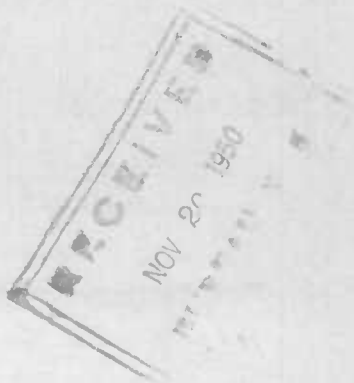
SIGNATURE John M. Claffy M.D., (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis Md. DATE SIGNED 11/17/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 20 1950
NAME OF CEMETERY OR CREMATORY Moreland Memorial Park
LOCATION (City, town, or county) Baltimore, (State) Maryland
DATE REC'D BY LOCAL REG. 11/18/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR R. V. Singleton, ADDRESS Glen Burnie Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A


RECEIVED
NOV 20 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10942

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sparrows Point, Md.
STREET ADDRESS (If rural, give location) 2503 Sycamore Street

3. NAME OF DECEASED (Type or Print): (First) Alexander (Middle) (Last) Yancy

4. DATE OF DEATH: (Month) Nov. (Day) 19 (Year) 1950

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: ~~not known~~ 1885

9. AGE last birthday: 65 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): not known

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. xxxxxxxxx

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Cerebral Hemorrhage	known since 11/18/50
331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a (b)	Generalized Arteriosclerosis	" "
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis " "

19a. DATE OF OPERATION: none | 19b. MAJOR FINDINGS OF OPERATION: none | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 11/18/50, 19....., to 11/19/50 19....., that I last saw the deceased alive on 11/19/50, 19....., and that death occurred at 9:40 P.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Marquette M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 11/20/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 11-24-50 | NAME OF CEMETERY OR CREMATORY Mt Calvary Cem | LOCATION (City, town, or county) (State) A A Co Md

DATE REC'D BY LOCAL REG. 11/24/50 | REGISTRAR'S SIGNATURE A. W. Hovrich | 24. FUNERAL DIRECTOR Rayner Sanders ADDRESS 1412 E. Preston St

MS

VS. A15